AmeriChoice a UnitedHealth Group Company
County of San Diego

Low Income Health Program & County Medical Services Specialty Referral Guidelines

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This document is periodically updated. Please visit the County Medical Services and Low Income Health Program website for the most up-to-date issue:
http://www.sdcounty.ca.gov/hhsa/programs/ssp/county_medical_services/index.html

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ALLERGY / IMMUNOLOGY

Criteria for Authorization

Allergy/Immunology patients might have, but are not required to have, the following labs/diagnostics in the 3 months prior to scheduling an appointment:

- CBC
- ESR
- RAST

Diagnoses treated in the Primary Care Clinic (and not Allergy/Immunology Clinic):
(This list is not intended to be a complete list, but examples of common conditions that should not be referred to Allergy/Immunology unless the patient has failed multiple treatments in the Primary Care Clinic.)

- Intermittent Urticaria
- Contact Dermatitis
- Allergic Rhinitis
- Eczema
- Suspected seasonal allergies

Diagnosis treated in the Allergy/Immunology Clinic:
(This list is not intended to be a complete list, but examples of conditions that are appropriate for referral to Allergy/Immunology Clinic):

- Patients with known Allergic Bronchopulmonary Aspergillosis (ABPA) for management.
- Patients with suspected or proven asthma or cystic fibrosis who have pulmonary infiltrates and peripheral blood eosinophilia
- Anaphylaxis : Individuals with a severe allergic reaction (anaphylaxis) with or without an obvious or previously defined trigger, such as food or medicine.
- Asthma Diagnosis: Patients with uncontrolled or severe asthma (prior severe, life-threatening episode; prior intubation). Consider referral for allergen immunotherapy for asthmatic patients if there is a clear relationship between asthma and

ALLERGY / IMMUNOLOGY (Continued)

exposure to an unavoidable aeroallergen to which specific IgE antibodies have been demonstrated and the following:

  - poor response to pharmacotherapy or avoidance measures
  - unacceptable side effects of medications
  - coexisting allergic rhinitis
  - long duration of symptoms (perennial or major portion of the year)

- Atopic and Contact Dermatitis: Patients whose atopic or contact dermatitis responds poorly to treatment AND interferes with ADLs and employment.
- Occupational Allergic Diseases: Workers in occupations with animal exposure, exposure to food proteins, or other potential allergens who experience chronic skin symptoms and/or respiratory symptoms attributable to the work environment.
- Rhinitis/Sinusitis: Patients with prolonged or severe manifestations of rhinitis with comorbid conditions (eg, asthma or recurrent sinusitis); with symptoms interfering with quality of life, ability to function, or both; who have found medications to be ineffective or have had adverse reactions to medications.
- Urticaria and Angioedema: Patients with chronic urticaria or angioedema (ie, those with lesions recurring persistently over a period of 6 weeks or more), urticarial vasculitis or urticaria with systemic disease (vasculidities, connective tissue disease, rarely malignancies), or chronically recurring angioedema without urticaria.

DERMATOLOGY

Criteria for Authorization

Dermatology patients might have, but are not required to have, the following labs/diagnostics in the 3 months prior to scheduling an appointment:

- CBC
- ESR
- VDRL
- RPR

Diagnoses treated in the Primary Care Clinic (and not Dermatology Clinic):
(This list is not intended to be a complete list, but examples of common conditions that should not be referred to Dermatology unless the patient has failed multiple treatments in the Primary Care Clinic.)

- Acne
- Warts
- Eczema
- Psoriasis
- Folliculitis
- Scars
- Total Body Checks
- Biopsy of a potentially malignant lesion (non-facial)

Diagnosis treated in the Dermatology Clinic:
(This list is not intended to be a complete list, but examples of conditions that are appropriate for referral to Dermatology Clinic)

- Bullous Pemphigoid
- Pemphigus Vulgaris
- Lupus Erythematosus
- Mycosis Fungoides
- Leprosy
- Epidermolysis Bullosa
- Biopsy of a lesion on the face, eyelid, or other area difficult to access
- Skin Malignancy

ENDOCRINOLOGY

Criteria for Authorization

Endocrinology patients must have the following labs/diagnostics prior to scheduling an appointment for the following diagnosis treated in the Endocrinology Clinic:

(This list is not intended to be a complete list, but examples of conditions that are appropriate for referral to Endocrinology Clinic if the patient has failed treatment in the Primary Care Clinic.)

Diabetes: labs within 3 months

- Logbook Record of fingerstick glucose (BID if possible)
- Diabetes Education Certificate/Diabetes Mgmt Note
- Nutritional Consult Completed (if available)
- CMP
- Lipid/Cholesterol Panel
- Urine Microalbumin/Creatinine Ratio
- HgA1c
- Blood Sugar High/Low

Hyperthyroid: labs within 3 months

- CMP
- CBC
- Lipid Panel
- TSH
- Free T4
- Total T3 (required if TSH abnormal)
- Thyroid peroxidase antibodies

Hypothyroid: labs within 3 months

- CMP
- CBC
- Lipid Panel
- TSH
- Free T4
- Thyroid peroxidase antibodies

Thyroid Nodules: labs within 3 months

- CMP

ENDOCRINOLOGY (Continued)

- CBC
- Lipid Panel
- TSH
- Free T4 (if TSH abnormal)
- Total T3 (if TSH abnormal)
- Thyroid ultrasound. If TSH low, need I-123 uptake and scan.
- Authorization for FNA by Endocrinologist available

Thyroid Cancer:

- Records of prior treatments/studies
- Surgical Pathology Report
- Thyroid Operative Report
- Thyroid Whole Body Scan, or more typically a "Thyrogen scan." For example, Scripps Memorial Radiology Dept is familiar with protocol to include a low iodine diet and specific timing of Thyroglobin.
- Post-Op Neck US to include central and lateral lymph node compartments.
- Chest CT and/or PET Scan in high risk patients
- Thyroglobulin
- Thyroglobulin Antibodies

Parathyroid: labs within 3 months

- BMP
- Ca
- PTH
- 25 hydroxyvitamin D

Hypercalcemia/Hyperparathyroid: labs within 3 months

- CMP
- CBC
- PTH
- Ca
- Urinary Ca
- Bone Mineral Density (DEXA)

Hypocalcemia: labs within 3 months

- CMP
- PTH

ENDOCRINOLOGY (Continued)

- CBC
- Ca
- Magnesium
- 25hydroxyvitamin D

Pituitary (Adenoma/Mass/Tumor): labs within 6 months

- BMP
- TSH
- Free T4
- Prolactin
- LH
- FSH
- 8am Cortisol and ACTH
- 8am Testosterone (if male)
- IGF-1
- 24 hour Urine Free Cortisol and creatininte. (May not be necessary in a patient with a prolactinoma or a patient without Cushingoid clinical findings.)
- Brain/Pituitary CT or MRI Report

Adrenal (Mass/Tumor/Incidentaloma): labs within 6 months

- BMP
- 24 hour urine cortisol and creatinine
- Plasma metanephrine
- 24 hour Urine Metanephrine
- Plasma Aldosterone
- Plasma Renin Activity
- Abdominal CT with contrast and washout study.

Adrenal Insufficiency: labs within 3 months

- BMP
- 8am Cortisol and ACTH
- Cosyntropin stimulation test

Osteoporosis: labs within 6 months

- CMP
- CBC
- 25-Hydroxy Vitamin D
- Bone Density Scan

Hypogonadism: labs within 6 months

ENDOCRINOLOGY (Continued)

- CMP
- CBC
- 8am Testosterone and sex hormone binding globulin
- LH and FSH (if not taking Testosterone), prolactin
- PSA

Gynecomastia: labs within 6 months

- CMP
- 8am Testosterone, LH,FSH,Quantitative betaHCG
- Prolactin
- TSH

Galactorrhea: labs within 6 months

- BMP
- Prolactin
- TSH
- CT/MRI Reports (if available)

Hirsutism: labs within 3 months

- DHEA-Sulfate (DHEAS)
- 17-Hydroxy Progesterone
- Sex hormone binding globulin
- Testosterone (random)
- CMP, FBS, Lipids, HgA1c

Pheochromocytoma: labs within 6 months

- BMP
- 24 hour Urine Metanephrines and creatinine
- This is a post op follow up

Amenorrhea: labs within 3 months

- Pregnancy Test
- CMP, FBS,Lipids,HgA1c
- Prolactin
- Estradiol
- FSH
- LH
- Testosterone
- 17-Hydroxy Progesterone

SIADH: labs within 3 months

ENDOCRINOLOGY (Continued)

- CMP
- Lipid Panel
- TSH
- Free T4
- Urine Osmol
- Urine Na
- Serum Osmol
- Cortisol-AM

GYNECOLOGY/ONCOLOGY

Criteria for Authorization

Gyn-Onc patients must have the following labs/diagnostics prior to scheduling an appointment (as appropriate):

- All diagnoses must be confirmed by pathological findings documented in a pathology report.
- Prior chemotherapy, operative and pathology reports as appropriate.

Diagnoses treated in the Primary Care (or Obstetrics/Gynecology) Clinic:
(This list is not intended to be a complete list, but examples of common conditions that should NOT be referred to Gyn-Onc unless the patient has failed multiple treatments in the Primary Care Clinic.)

- Low or Moderate grade Cervical pathology: LGSIL, CIM 1-2.
- Pre menopausal females with Ovarian and Fallopian tube masses need imaging to determine size of mass.
- Low grade VAIM 1-2.
- Placenta Percreta, a condition in which the placenta grows outside the uterus, should be referred to UCSD Perinatology.

Diagnosis treated in the Gyn-Onc Clinic:

- Diagnosed Untreated Cancer:
  - Cervical Cancer.
  - Ovarian and Fallopian Tube malignancy.
  - Post menopausal patients with pelvic mass.
  - All patients with masses >8 sonometers regardless of age. (CA 125 is helpful, but not required).
  - Uterine, endometrial and sarcoma cancer.
  - Vaginal/ Vulvar Melanoma.
- Suspected / Undiagnosed Cancer (pre-cancer)
  - Dysplasia: high grade CIM 2-3 or CIS 2-3.
  - Cyst and Lesions: high grade VIM 2-3.
- Previously Treated or Recurring Cancer
  - Must have had treatment or active disease within the last 5 years.

HEAD AND NECK SURGERY

Bell's Palsy

- Refer to HNS if:
  - Total paralysis not responding to high dose prednisone for 1 to 2 weeks
- Refer to NEUROLOGY if:
  - Associated with other neurological findings / signs of intracranial disease

Dysphagia

- Refer to HNS if:
  - Associated with hoarseness or neck mass
- Pertinent Clinical Findings:
  - Persistent difficulty in swallowing liquids and or solids
- Consider prior to referral:
  - XR BARIUM SWALLOW (within 3 months)
- Treatment Recommendations:
  - Reflux treatment (H2 blocker or PPI) x 6 weeks, if no weight loss or hemoptysisis

Epitaxis

- Refer to HNS if:
  - Bleeding recurrent but not actively bleeding
  - Nasal mass
- Pertinent Clinical Findings:
  - Determine whether:
    - Bleeding is unilateral or bilateral
    - Bleeding is anterior or posterior
  - Any bleeding diathesis or hypertension
  - Med review: ASA, Motrin/NSAIDS, nasal steroid spray, coumadin, Vit E, ginko
  - Coagulation studies
  - Digital trauma

Facial Fracture

- Pertinent Clinical Findings:
  - Evaluate extraocular muscles are intact, vision with attention to diplopia
  - "Feel" for step-offs along orbital rims
  - Assess changes in oral occlusion
  - Neuro exam (II-XII, with emphasis on V, VII)

HEAD AND NECK SURGERY (Continued)

- Consider prior to referral:
  - CT FACIAL BONES NO CONTRAST (of midface – axial and coronal) (within 1 week)

Facial Skin Lesions (Nevi, Skin Cancer)

- Refer to HNS if:
  - Benign lesion is symptomatic or changing
  - Malignant lesion when biopsied and photographed for excision
- Refer to Ophthamology if:
  - Lesion is located on eyelid
- Refer to Dermatology if:
  - Lesion has not yet been biopsied
- Pertinent Clinical Findings:
  - Benign skin lesion: changing nevi, EIC's, growing / infected / changing skin lesions
  - Malignant skin lesion: Biopsy positive

Hearing Loss Evaluation / Audiogram

- Refer to Audiology if:
  - Long standing hearing loss with normal appearing tympanic membrane
- Pertinent Clinical Findings:
  - Sudden Hearing Loss
    - Sudden sensorineural hearing loss develops instantaneously or over a few hours. Unilateral in 98% of cases. Idiopathic, with commonly accepted theories being viral, vascular, a combination of both, or inner ear membrane breaks.
    - Evaluation of hearing loss using tuning fork:
      - Weber – Fork placed on midline forehead or teeth
        - If midline, then normal
        - If towards good ear, then possible sensorineural hearing loss in bad ear

HEAD AND NECK SURGERY (Continued)

- ◊ If towards bad ear, then possible conductive hearing loss in bad ear (Refer to AUDIOLOGY)
- ♦ Rinne – Used as a screening tool
  - ◊ If air conduction tests is louder than bone conduction (positive Rinne) then possible sensorineural loss

Hoarseness

- Refer to HNS if:
  - Hoarseness persists more than 2 weeks despite medical therapy
- Pertinent Clinical Findings:
  - History of tobacco / alcohol use
  - Neck / thyroid mass
  - Recent URI
  - Evaluation, when indicated:
    - Hypothyroidism
    - Diabetes mellitus
    - GERD
    - Neoplasm: Lung, Esophageal

Nasal Fracture

- Refer to HNS if:
  - NEW persistent nasal deformity

**No referral to HNS indicated if no nasal obstruction and no change in nose appearance*

- Pertinent Clinical Findings:
  - Intranasal exam to exclude septal hematoma (can feel an expansion of the septal mucosa which is soft, using a cotton tip applicator)
  - Evaluate extraocular muscles are intact, vision with attention to diplopia
  - "Feel" for step-offs along orbital rims
  - Assess changes in oral occlusion
  - Neuro exam (Cranial nerves II-XII, with emphasis on V, VII)

HEAD AND NECK SURGERY (Continued)

Nasal Obstruction / Septal Deviation

- Refer to HNS for:
  - Persistent symptomatic nasal obstruction
  - Unilateral or bilateral Septal deviation
  - History of facial / nasal trauma
  - Obstructive nasal polyps

Neck Mass

- Refer to HNS if:
  - Mass persists for 2 weeks without improvement
- Refer to Endocrinology if:
  - Possible thyroid problem, unless compressive symptoms, voice change, or dominant nodule
- Pertinent Clinical Findings:
  - Complete H&N exam
  - Possible URI or dental origin
  - Painful masses tend to be inflammatory in origin
  - Consider inflammatory workup:
    - CBC
    - Monospot
    - Throat cultures if indicated
    - TB test
    - Inquire about possible cat scratch (bartonella – saliva)
    - HIV testing if indicated
    - Toxoplasmosis titer if indicated (parasite – cat feces)
  - If lower neck / thyroid evaluation may include:
    - Thyroid function studies
    - Thyroid ultrasound

Obstructive Sleep Apnea

- Refer to HNS for:
  - Significant symptoms of upper airway obstruction, usually associated with open mouth posture and sleep disturbance
- Consider prior to referral:

HEAD AND NECK SURGERY (Continued)

- Polysomnogram to be obtained prior to referral if symptoms not associated with adenotonsillar hypertrophy

Oral Lesion

- Refer to HNS for:
  - Evaluation of excision of benign lesions, malignant lesions or mucoceles needed
  - Isolated lesion, assess tenderness
- Pertinent Clinical Findings:
  -
  - Concerning factors for malignancy:
    - High-risk patient: EtOH, Smoking, chewing tobacco, immunocompromised
    - Ulceration
    - Associated cervical lymphadenopathy
- Consider prior to referral:
  - CT SOFT TISSUE OF NECK, W CONTRAST (if suspected malignancy associated cervical lymphadenopathy or oral / tonsil lesion large) (within 3 months)

Otitis External Acute

- Refer to HNS if:
  - Unresponsive to initial course of wick and anti-bacterial drops

Otalgia – Ear Pressure

- Refer to HNS for:
  - Persistent ear discomfort especially in high risk patients of ETOH and tobacco
- Consider prior to referral:
  - If eustachian tube / rhinitis consider steroidal nasal spray and saline irrigations for 6 weeks

Otitis Media

- Refer to HNS if:
  - No improvement after 2 courses of antibiotics treatment

HEAD AND NECK SURGERY (Continued)

Perforated Tympanic Membrane

- Refer to HNS if:
  - Draining ear or cerumen impaction or chronic perforation
  - Asymptomatic dry tympanic membrane perforation
- Pertinent Clinical Findings:
  - Associated symptoms:
    - Drainage
    - Hearing loss
    - Vertigo

Sinusitis w/ Nasal Polyps

- Refer to HNS if:
  - Persistent despite medical management (symptoms greater than 3 months)
- Consider prior to referral:
  - CT SINUS, NO CONTRAST (If symptoms are chronic/persistent) (within 3 months)

Tinnitus

- No referral indicated unless pulsatile, or associated hearing loss or dizziness
- Pertinent Clinical Findings:
  - Clinical Evaluation: History to include questioning for hearing loss, balance problems etc. Exam to include evaluation of tympanic membrane. In cases of pulsatile tinnitus need to auscultate neck and scalp for bruits.
  - Tinnitus will be either tone / static or pulsatile
  - Exclude cerumen, middle ear fluid, mass
  - Exclude medication side effects
- Consider prior to referral:
  - Diagnostic Tests: Audiological evaluation to assess cochlear and middle ear function, consisting of air conduction, bone conduction, speech discrimination, tympanogram and acoustic reflex testing.

HEAD AND NECK SURGERY (Continued)

Vertigo

- Refer to HNS if:
  - Symptoms become severe
  - Associated hearing loss, increased severity, persistence greater than 6 weeks

HEPATOLOGY

Criteria for Authorization

Hepatology patients must have the following labs/diagnostics prior to scheduling an appointment:

- Labs within the last 3 months (CMP, Liver panel, GGT, CBC with Diff, PT/INR,AFP, Iron Sat %)
- Serology within the last 3 months:
  - Anti-HBs
  - HBsAg (and if positive)
    - HBV DNA quant
    - HBeAg
    - Anti-Hbe
    - US of liver with PV size and Spleen size
  - Anti-HBc
  - Anti-HAV (total IgG)
  - Anti-HCV (and if positive)
    - HCV RNA quant
      - ♦ If HCV RNA quant positive, then do HCV Genotype and RhF and US of liver with PV size and Spleen size

If elevated liver tests and iron, HBV and HCV negative, then there is a need to work up for AIH and metabolic disease:

- Immunologic Studies:
  - Quant Immunoglobulin Panel
    - ANA
    - Anti-F actin
  - Alpha 1 antitrypsin level
  - Ceruloplasmin
  - BMI
  - Hgb a 1 c
  - Fasting Blood Sugar

If ALT >200 or suspected acute liver disease, need:

- Blood alcohol
- Tox screen
- Acetaminophen level
- HBV core IgM
- HAV IgM
  - Anti-HBs
  - Anti-HBsAg (and if positive)

HEPATOLOGY (CONTINUED)

- HBV DNA quant
- HBeAg
- Anti-Hbe
- Anti-HCV
- US of liver with PV size and Spleen size

- Diagnostic Studies (if done): (If studies were done outside UCSD please have patient bring copy or CD of the studies to their appointment.)
  - MRI
  - CT scan
  - US
  - EGD/Colonoscopy
  - Liver Biopsy, patient to bring glass slides

Diagnoses treated at the Hepatology Clinic:
(This list is not intended to be a complete list, but examples of conditions that are appropriate for referral to Hepatology Clinic.)

- Autoimmune Liver Disease (Requires Immunologic Studies)
- Cirrhosis
- Fatty Liver
- Hemochromatosis
- HCV
- HBV
- Wilson Disease
- Budd Chiari
- Unexplained liver test elevation
- Acute liver disease
- NASH
- Alcoholic liver disease
- Liver Mass /Cancer (confirmed diagnosis by imaging/biopsy)

Urgent Appointments are indicated for:

- Liver Mass
- Liver failure, with complication of cirrhosis such as: jaundice, ascites, GI bleeding
- Acute liver disease with Total Bilirubin >2.0

NEPHROLOGY

Criteria for Authorization

Nephrology patients must have the following labs/diagnostics in the 3 months prior to scheduling an appointment:

- CBC
- CMP (serum BUN/ Cr, eGFR, Urinalysis (with Micro), Microalbumin
- HgA1c (if diabetic)
- Renal Ultrasound (if warranted)
- 24 hour urine for creatinine and protein
- Blood Pressure measurement

Diagnoses treated in the Primary Care Clinic (and not Nephrology Clinic):
(This list is not intended to be a complete list, but examples of common conditions that should not be referred to Nephrology unless the patient has failed multiple treatments in the Primary Care Clinic.)

- Diabetic or Hypertensive patients with normal microalbumin, serum Cr, and eGFR

Diagnosis treated in the Nephrology Clinic:
(This list is not intended to be a complete list, but examples of conditions that are appropriate for referral to Nephrology Clinic)

- Serum Creatinine of 2.0 or higher in the last 3 months
- eGFR of 30 or lower in the last 3 months

NEUROLOGY

Criteria for Authorization

Neurology patients must have the following labs/diagnostics prior to scheduling an appointment (as appropriate):

- History with particular attention to medications, history of prior strokes, age of onset of symptoms, alcohol consumption and family history of similar symptoms
- Complete Neurological Exam on physical exam.
- Acute Low Back pain with red flags warrant: plain radiographs (AP, Lateral, and Spot Views); CBC with differential; ESR; C-Reactive Protein. Consider bone scan; CT scan or MRI scan and electrodiagnostics as indicated. Generally MRI would be preferred. (If red flags are absent a diagnostic workup is generally not necessary.)
- Red Flags for Acute Low Back Pain include:
  - age <18 or >55
  - history of malignancy
  - steroid use
  - HIV positivity
  - constitutional symptoms (fevers, chills, unintended weight loss)
  - structural deformity
  - anal or urethral sphincter disturbance
  - saddle anesthesia
  - gait disturbance
  - or widespread neurologic deficit
- Labs (Glucose, TSH, etc.)
- Neurology diagnostic test results (EMG, NCV)
- Radiology studies as needed (CT, MRI)

Diagnoses treated in the Primary Care Clinic:

Acute low back pain

- Initial treatment for the first 4-6 weeks of uncomplicated acute low back pain.
- Low Back Pain unresponsive to conservative management without radiculopathy should be referred to Physical Therapy for additional nonsurgical, treatment modalities.

NEUROLOGY (Continued)

CVA

- Management of stable patients who receive the following treatment:
- Any patient with a new neurologic deficit concerning for stroke should be evaluated in the ER. Time is critical as certain stroke medications may be used only in the first three hours after a stroke.
- Acute stroke management should include a detailed neurologic history and physical, imaging with head CT with CT angiogram initially, and MRI +/- MRA, carotid & vertebral U/S, Echo and lab work up (CBC, Chem 10, Coagulation studies, and Lipids).
- If the patient had onset of symptoms > 5 days ago and is stable, the above workup may be performed as an outpatient. It should be expedited (in 1 week or less).
- Stroke in person <50yo: consider bubble study. If positive, consider trans-esophageal echocardiogram (TEE).

Migraine headache

- Headache pattern stabilizing on no medication or on chronic medication.
- In opinion of neurologist, headaches can be managed by primary care with neurology input on a prn basis.
- PCP completes history and physical examination including neurologic exam.
- MR/CT imaging indicated if:
  - There are focal neurological signs/symptoms.
  - The headache pattern is changing.
  - The history suggests seizure disorder.
- PCP focus is : Identify and reduce triggers, educational behavioral therapies, lifestyle evaluation (cessation of smoking, discussion of contraceptive methods, regular exercise).
- Determine headache frequency:
  - Weekly or less frequently: generally only abortive therapy required unless severe

impact on patient's life, unresponsive to abortive agents, etc.

- Weekly or more frequently: emphasis must be on prophylaxis. Abortive agents can be regularly used no more than 2x per week to avoid risk for rebound.

- Prophylactic therapy: Reduces frequency and/or intensity by at least 50%. Appropriate agents include tricyclics, beta-blockers, valproic acid, calcium channel blockers, or topiramate.
- Abortive therapy: Reduce severity of attacks. Appropriate abortive agents include isometheptene, non-steroidal anti-inflammatory agents, ergotamine, triptans.

Transient Impairment of Consciousness

- Work up for a credible history of impairment or loss of consciousness with complete return to mental status baseline in 24 hours or less includes:
- History and physical examination, including neurologic, cardiologic and a supervised period of at least 3 minutes of hyperventilation.
- Electrocardiogram, serum glucose, electroencephalogram (EEG), thyroid screen and holter if clinically indicated.
- Management by Primary Care if Neurology opines that cause is not within the nervous system, and/or underlying cause treated and stabilized, manageable by primary care with occasional or prn neurologic input.

Tremor

- History by PCP with particular attention to medications, history of prior strokes, age of onset, suppression of tremor with alcohol consumption and family history of similar symptoms.
- Physical exam should define tremor as resting, coarse or fine, postural or intention tremor. Also, physical exam should look for evidence of cerebellar involvement, weakness or loss of proprioception.

NEUROLOGY (Continued)

- With no other physical findings: Fine tremor with no other physical findings is likely physiologic and requires no treatment. Coarse postural tremor in patient on lithium or depakote is likely an effect of the medication. Coarse postural tremor with positive family history (familial essential tremor) in young patient suppressed by alcohol (essential tremor), or in elderly patient (senile tremor) can be given trial of medication if there are no contraindications. Usual agents are propranolol or primidone. Resting tremor with associated features (or without in early stages)-consider Parkinson's Disease in the differential diagnosis.
- In patients with isolated tremor, the goal of therapeutic intervention is the reduction in the tremor to the point where it does not affect the functioning of the patient (i.e., their ability to write, eat or work) without the patient experiencing side-effects from the medications being used as treatment.

Diagnoses seen at Neurology Clinic

Acute low back pain

- Focal neurologic signs (muscle weakness, loss of reflexes) with supporting abnormal MRI findings (disk herniation, tumor, deformity) – (or consider Neurosurgery referral)
- Focal neurologic signs with abnormal imaging studies (or consider Neurosurgery referral. Obtain MRI prior to referral (without contrast unless tumor suspected).
- Focal neurologic signs with normal imaging studies - Neurology referral.
- Incapacitating radiculopathy unresponsive to therapy with supporting abnormal MRI Findings – consider Neurosurgery or Orthopedic referral.
- Abnormal plain radiographs associated with red flags – consider Neurosurgery or Orthopedics referral. MRI of lumbar spine prior to referral
- Loss of bladder or bowel control, Saddle Anesthesia – If symptoms acute (less than 72

NEUROLOGY (Continued)

hours), patient warrants expedited evaluation. If symptoms subacute or chronic and supporting abnormal MRI findings present, consider Neurosurgery or Orthopedic referral. If supporting abnormal MRI findings are not present, consider referral to urology or gastroenterology.

CVA

- New neurologic deficits, recurring symptoms while on antiplatelet therapy, and/or uncertain diagnosis.

Migraine headache

- If diagnosis in doubt, if focal neurological symptoms or signs, and/or if patient has failed at least two trials of appropriate therapies.

Transient Impairment of Consciousness

- History suspicious for seizure disorder, abnormal neurological exam in which case head imaging should be added to pre-referral test list., and/or abnormal EEG.

Tremor

- Uncertain diagnosis.
- Asymmetric neurological exam, weakness or coordination difficulties present.
- Patient diagnosed with essential tremor, who has failed trials of appropriate medications.

UCSD CENTER FOR PAIN MEDICINE (CPM)

Criteria for Authorization

Patients referred to the CPM must meet the following criteria:

- The patients's Primary Care Physician (PCP) must be involved in the ongoing care of the patient.
- The CPM will stabilize the patient and then return the patient to the PCP with recommendations for ongoing care.
- The CPM will not accept a referral from a physician (PCP or Specialist) who will not follow up with the patient and the CPM recommendations.

Diagnoses seen at the CPM Procedure Clinic

- Only epidural steroid injections, sacroiliac joint injections and trigger point injections can be referred directly to the procedure clinic.
- All other injections require a pain clinic evaluation prior to scheduling at the CPM Procedure Clinic.

REQUEST FOR ALL PAIN MANAGEMENT ECONSULTS

Before referring a patient with **back or neck pain** or with suspected **radicular pain** for Pain Management Consultation, please ensure that the following have occurred:
Please provide a history that indicates the following:

- when and how the pain started,
- where in the body the pain is located (right left, midline, lumbar, buttock/shoulder or extremity),
- whether pain is constant or intermittent
- what factors, activities or movements provoke the pain or make it worse and what factors make it better.
- are there any "red flag" findings such as signs of infection, signs of malignancy, numbness, weakness or bowel and bladder impairment that suggest other urgent referral is necessary.

The patient should have a physical examination which illuminates the following:

- limitation on range of motion of the lumbar/cervical spine flexion, extension and rotation to the right and left (and is the patient's usual pain provoked on any of these movements).
- tenderness at the lumbar/cervical midline, paraspinous musculature or buttocks/inter-scapular region.
- any asymmetry on the extremity manual motor exam, sensory exam to light touch or pin prick and lower extremity reflexes.
- babinski or hoffman's bilaterally
- does straight leg raising cause familiar pain and is it in the back, buttock or leg.

Unless there is a clear radicular pain, the patient should have been through a trial of physical therapy.

RHEUMATOLOGY

Criteria for Authorization

Rheumatology patients must have the following labs/diagnostics prior to scheduling an appointment (as appropriate):

Statements of previous history or diagnosis are not acceptable without supporting evidence of diagnosis.

- X-ray findings (lesions, erosive changes, nodules)
- Labs (RF, ANA, CRP, ESR, etc.)
- Medication list (Methotrexate, Plaquinil, Enbrel, Remcaid, etc.)
- Prior treatment, operative and pathology reports as appropriate.

Diagnoses treated in the Primary Care Clinic:

(This list is not intended to be a complete list, but examples of common conditions that should NOT be referred to Rheumatology unless the patient has failed treatment in the Primary Care Clinic.)

- Fibromyalgia: Current studies show little or no benefit in long term outcomes in patients based on rheumatology interventions or evaluation.
- Uncomplicated Osteoarthritis
- Arthralgias with positive rheumatoid factor. The positive predictive value of this test is very low without clear evidence of synovial inflammation in characteristics joints.
- Positive Serologies especially ANA, with no other clinical or laboratory criteria of SLE, such as arthritis, photosensitive skin rash, nephritis, etc.

Diagnosis treated in the Rheumatology Clinic:
In order for a patient to be accepted into the Rheumatology Clinic the patient must present with all of the following three criteria to support diagnosis of autoimmune disorder.

- Physical Exam findings consistent with inflammatory process (redness, warmth, swelling, deformity)
- Abnormal laboratory findings
- Abnormal imaging studies

UROLOGY

Criteria for Authorization

Urology patients must have the following labs/diagnostics prior to scheduling an appointment (as appropriate):

- Urinalysis (microscopic), Urine Culture
- PSA, CBC, BUN/Cr
- Pathology reports
- Radiology studies as needed (US, IVP, etc.)

Diagnoses treated in the Primary Care Clinic:

- Erectile Dysfunction
- Urinary Tract Infections (uncomplicated)
- Family Planning / Infertility (NCB under CMS)

Diagnoses seen at Urology Clinic

- Diagnosed Untreated Cancer (confirmed by Imaging Studies)
  - Positive Prostate Biopsy
  - Renal Mass
  - Bladder Tumor
  - Testicular Mass

- Suspected/Undiagnosed Cancer
  - Gross Hematuria
  - Elevated PSA

- Acute Stone (confirmed by Imaging Studies)
  - Diagnosed Stone
  - ER follow up

- Urinary Retention
  - ER follow up

- Previously Treated Cancer Follow up
  - Bladder Cystoscopy
  - Post Prostatectomy
  - Surgery
  - Chemo
  - XRT

- Spinal Cord Injured patients
  - Catheter Change

UROLOGY (Continued)

- Retained Stents

- Complicated Urinary Tract Infections
  - 5 or more infections within the last 12 months

- Hematuria
  - >5 (greater than five RBC on microscopic urinalysis)